

Audiology Services and Hearing Aid Services

***Medicaid and Other Medical
Assistance Programs***

This publication supersedes all previous Audiology Services and Hearing Aid Services handbooks. Published by the Montana Department of Public Health & Human Services, June 2006.

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My Medicaid Provider ID Number:
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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-9641 or 442-1837

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions or issues:

(406) 444-4068 DMEPOS Program Officer
(406) 444-5296 Claim Specialist
(406) 444-1861 Fax

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:

MTEDIHelpdesk@ACS-inc.com

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone

(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

For prior authorization for hearing aids (see the *Prior Authorization and PASSPORT* chapter in this manual) contact:

Department of Public Health
and Human Services (DPHHS)
Health Resources Division—
Medicaid Acute Services Bureau
ATTN: DMEPOS Program Officer
P.O. Box 202951
Helena, MT 59620-2951

Key Websites	
Web Address	Information Available
Provider Information Web Portal www.mtmedicaid.org or www.dphhs.mt.gov/medicaid/	<ul style="list-style-type: none"> • Medicaid information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more • Log in to Montana Access to Health
Client Information Website http://www.dphhs.mt.gov/medicaid/clientpages/clientindex.shtml	<ul style="list-style-type: none"> • Medicaid program information • Client newsletters • Who to call if you have questions • Client notices and information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • Provider Services • EDI support • Enrollment • Manuals • Software • Companion guides
ARM Rules http://www.dphhs.mt.gov/legal_section/administrative_rules_montana/arm_title_37/arm_title_37.htm	Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education
CHIP Website www.chip.mt.gov	<ul style="list-style-type: none"> • Information on the Children's Health Insurance Plan (CHIP)

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for providers of audiology services and hearing aid services. Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). The following rules and regulations are specific to the Audiology Services and Hearing Aid Services programs. Additional Medicaid rule references are available in the *General Information For Providers* Manual.

- Administrative Rules of Montana (ARM)
 - ARM 37.86.701 - 37.86.705 Audiology Services
 - ARM 37.86.801 - 37.86.805 Hearing Aid Services



Providers are responsible for knowing and following current laws and regulations.

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by audiology service and hearing aid providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual.

Services provided by audiologists

Audiologists must hold a current audiology license issued by the Montana Board of Speech Language Pathologists and Audiologists under Title 37, Montana Codes Annotated, be enrolled as a Montana Medicaid provider and be the provider of the service. If the provider is serving recipients outside Montana, he or she must maintain a current license in the equivalent category under the laws of the state in which the services are provided. Audiology services are hearing aid evaluations and basic audio assessments provided to clients with hearing disorders within the scope of service permitted by state law.

Hearing aid services

Dispensers who provide hearing aids for purchase or rental must be licensed by the Montana Board of Hearing Aid Dispensers to engage in selling, dispensing or fitting hearing aids provided in accordance with all applicable Medicaid requirements and within the scope of practice permitted under the dispenser's license.

Services for children (ARM 37.86.2201 – 2221)

Clients age 20 and under will be evaluated under the Well Child Early and Periodic Screening, Diagnosis and Testing (EPSDT) service, which covers all medically necessary services for children age 20 and under.

Supplier documentation (ARM 37.86.702)

Audiology services must be referred by a physician or mid-level practitioner. The referral must indicate that a hearing aid would be medically appropriate to correct the patient's hearing loss. Verbal referrals must be followed up by a written order received by the provider within 30 days. Referrals and orders are valid for Medicaid purposes for no more than 90 days.

Written orders, diagnostic and evaluation reports, and appropriate records that demonstrate compliance with Medicaid requirements, must be current and available upon the request of the Department or its designated representatives at no charge.

The audiologist's written report must document the medical necessity for the service and shall contain the following information:

- The client's name, date of birth, and Medicaid identification number.
- Results of audiometric tests at 500, 1,000, 2,000 and 3,000 hertz for the right and left ears, and word recognition or speech discrimination scores at levels which ensure pb max.
- A written summary regarding the results of the evaluation indicating, in his or her professional opinion, whether a hearing aid is required, the type of hearing aid (e.g. in-the-ear, behind-the-ear, body amplifier, etc.) and whether monaural or binaural aids are requested.
- The audiologist's name, address and license number in typed or pre-printed form.
- The audiologist shall sign and date the form.

The audiologist should give a copy of the report to the client to take to the hearing aid dispenser (if the audiologist is not providing the hearing aid). The audiologist retains the original report in the individual's medical file. The hearing aid dispenser will submit the audiologist's report to the Medicaid Program for approval of the hearing aid before dispensing of the aid(s).

For additional documentation requirements, see the *General Information for Providers* manual, *Provider Requirements* chapter.

Request for Authorization

Hearing aids require prior authorization. A Request for Authorization form is required to provide supporting documentation for the client's medical indication(s). The "PA" column of the Montana Medicaid fee schedule indicates if prior authorization is required. The Request for Authorization form is available in *Appendix A: Forms* and on the Provider Information website (see *Forms*).

Rental/purchase

Rental of hearing aids is limited to 30 days. Montana Medicaid does not reimburse for a separate dispensing fee on rentals.

Non-covered services (ARM 37.85.207 and 37.86.205)

Some services not covered by Medicaid include the following:

- Services considered experimental or investigational.
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
 - Medical emergency.
 - Required medical services are not available in Montana. Prior authorization may be required; see the *PASSPORT and Prior Authorization* chapter in this manual.

- If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state.
- When out-of-state medical services and all related expenses are less costly than in-state services.
- When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state.
- Medicaid does not cover services that are not direct patient care such as the following:
 - Missed or canceled appointments.
 - Mileage and travel expenses for providers.
 - Preparation of medical or insurance reports.
 - Service charges or delinquent payment fees.
 - Telephone services in home.
 - Remodeling of home.
 - Plumbing service.
 - Car repair and/or modification of automobile.
- Some able-bodied, employable adults age 21 and older are on Montana's welfare reform project known as FAIM (Families Achieving Independence in Montana). The provider must verify eligibility (see *Key Contacts*) to determine if these clients have FULL or BASIC Medicaid. Individuals with BASIC are NOT eligible for audiology or hearing aid services, unless the exam is needed for hearing aid services relative to employment reasons. Staff at the local Public Assistance Office will assist these clients in completing the "Essential for Employment" paperwork to determine if Medicaid may reimburse for the hearing exam and/or hearing aid. All criteria stated in this manual also must be met.
- Warranty fee/replacement fee and/or deductible for replacing a lost hearing aid within the two-year warranty period.

Verifying coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are specific criteria for certain items/services Medicaid covers that are either in addition to Medicare requirements or are services Medicare does not cover.

Basic audio assessments and hearing aid evaluations

Basic audio assessments (BAA) must include at a minimum, for each ear, under ear phones in a sound-attenuated room:

- Speech discrimination (word recognition) test under pb max conditions.
- Speech reception thresholds.
- Pure tone air conduction thresholds (at the frequencies of .5, 1, 2, 3, and 4 KHZ).
- Either pure tone bone thresholds at the above frequencies or tympanometry including tympanogram with acoustic reflexes and static compliance.

Hearing aid evaluation (HAE) includes those procedures necessary to determine the acoustic specifications most appropriate for the individual's hearing loss.

Reimbursement for BAA or HAE includes all related supplies and items used in the performance of the assessment or evaluation.

Hearing aids

For a hearing aid to be covered, the client must be referred by a physician or mid-level practitioner for an audiological exam, and the physician or mid-level practitioner must have determined that a hearing aid would be medically appropriate to correct the patient's hearing loss.

A hearing aid will be covered if the examination by a licensed audiologist results in a determination that a hearing aid or aids are needed, and either of the following criteria is met:

- For persons age 21 and older, the audiological examination results show that there is an average pure tone hearing loss of at least 40 decibels for each of the frequencies of 500, 1,000, 2,000 and 3,000 Hertz in the better ear and word recognition or speech discrimination scores are obtained at a level to ensure pb max.
- Persons age 20 and under are evaluated under the Well Child Early and Periodic Screening, Diagnosis and Testing (EPSDT) service. The

Department or its designee determines after review of the audiology report that the hearing aid would be appropriate for the person. For more information on the EPSDT program, see the *Physician Related Services* manual.

Medicaid payment covers the manufacturer's invoice price (excluding warranty charges) of the hearing aid. The invoice must contain the hearing aid model and serial number. Medicaid also will pay a dispensing fee (see *Hearing aid fitting* below).

Monaural hearing aids

Monaural hearing aids are covered for invoice cost up to \$400.

Binaural hearing aids

For coverage of binaural hearing aids for adults ages 21 and older, **all** of the following criteria must be met:

- The two-frequency average at 1 KHZ and 2 KHZ must be greater than 40 decibels in both ears;
- The two-frequency average at 1 KHZ and 2 KHZ must be less than 90 decibels in both ears;
- The two-frequency average at 1 KHZ and 2 KHZ must have an interaural difference of less than 15 decibels;
- The interaural word recognition or speech discrimination score must have a difference of not more than 20 percent;
- Demonstrated successful use of a monaural hearing aid for at least six (6) months; and
- Documented need to understand speech with a high level of comprehension based on an educational or vocational need.

Binaural hearing aids are covered for invoice cost up to \$800.

Hearing aid fitting

The provider may bill Medicaid for a dispensing fee as specified in the fee schedule, in addition to the invoice price for the purchase of the hearing aid or aids. Hearing aid fitting must include either sound field testing in an appropriate acoustic environment or real ear measurements to determine that the hearing aid adequately fits the client's needs. It also must include at least one follow-up visit and warranty coverage for the hearing aid for a period of at least two years.

Hearing aid replacement

For clients age 21 or over, a hearing aid purchased by Medicaid will be replaced no more than once every five years and only if:



Use the current fee schedule for your provider type to verify coverage for specific services.

- The original hearing aid has been lost or irreparably broken after the warranty period;
- The provider's records document the loss or broken condition of the original hearing aid; and
- The hearing loss criteria specified in this manual continue to be met; or
- The original hearing aid no longer meets the needs of the individual and a new hearing aid is determined to be medical necessary by a licensed audiologist.

Hearing aid miscellaneous codes

When a provider bills with a miscellaneous code, a description of the item is required or payment will be denied.

Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

Prior Authorization and PASSPORT

What Are PASSPORT, Team Care and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120)

PASSPORT To Health, prior authorization (PA) and the Team Care Program are examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. **PASSPORT approval is not required for audiology or hearing aid services.**

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately \$20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *PASSPORT To Health* manual.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *PASSPORT To Health* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim.

Medicaid does not pay for services when prior authorization requirements are not met.



Prior Authorization (ARM 37.85.410, 37.86.1806)

To ensure federal funding requirements are met, certain items/services are reviewed before delivery to a Medicaid client. These items/services are reviewed for appropriateness based on the client's medical need. In determining medical appropriateness of an item/service, the Department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

If an item/service is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item/service to the client.

When requesting prior authorization, remember:

- Only Medicaid enrolled providers may request PA for items/services.
- Documentation must support medical necessity.
- Documentation must coincide with other documentation provided by those involved with the client.
- Documentation must be complete, including appropriate signatures and dates.
- Client must be eligible for Medicaid.
- Use current correct coding.

To request prior authorization for an item/service:

- Submit a completed *Request for Prior Authorization Form* (see *Appendix A: Forms*).
- Submit a completed Certificate of Medical Necessity (see *Appendix A: Forms*).
- Include appropriate supporting documentation with the request (see the following *PA Criteria* table).
- Fax or mail the request and supporting documentation to the Department (see the following *PA Criteria* table).
- Upon completion of the review, the client and the requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations (see *Key Contacts*).

Granting of prior authorization does not guarantee payment for the item/service.



PA Criteria		
Covered Service	PA Contact	Requirements
<ul style="list-style-type: none"> • Hearing aid and dispensing fee • Hearing aid for clients under 21 years of age 	Department of Public Health and Human Services (DPHHS) Health Policy and Services Division— Medicaid Services Bureau P.O. Box 202951 Helena, MT 59620-2951	Medical necessity documentation must include all of the following: <ul style="list-style-type: none"> • Completed Request for Prior Authorization form. • Completed CMN form. • Supporting documentation, which must include at a minimum: <ul style="list-style-type: none"> • A copy of the physician or mid-level practitioner's referral • An audiogram • A report from the licensed audiologist

No prior authorization is required for hearing aid services and supplies or the handling fee for hearing aid repairs or batteries.

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, Workers' Compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (TPL). See the *General Information For Providers* manual, *Client Eligibility and Responsibilities*. If Medicare or other carrier information is known, the Medicare ID number is provided or the carrier is shown on the eligibility information. Some examples of third party payers include:

- Private health insurance.
- Employment-related health insurance.
- Workers' Compensation Insurance.*
- Health insurance from an absent parent.
- Automobile insurance.*
- Court judgments and settlements.*
- Long term care insurance.

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability or TPL, but Medicare is not considered a TPL.

Medicare Part B crossover claims

Medicare does not cover hearing aids and exams for fitting hearing aids. Hearing and balance exams to see if medical treatment is needed are covered under Medicare Part B only when ordered by the client's physician. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]) under which the carriers provide the Department with a magnetic tape of professional claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When clients have both Medicare and Medicaid covered claims, and the provider has made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

When submitting electronic claims with paper attachments, see *Billing Electronically with Paper Attachments* in the *Submitting a Claim* chapter in this manual.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

In order to avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

All Part B Crossover claims submitted to Medicaid before the 45-day response time from Medicare will be returned to the provider.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this obligation, "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid." Payments can be sent to the Third Party Liability Unit (see *Key Contacts*).

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by Indian Health Services (IHS) or Crime Victim's Compensation, providers must bill Medicaid first. These are not considered a third party liability.
- When a client has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification to the Third Party Liability Unit (see *Key Contacts*).
- Audiology services, hearing aids and batteries may be billed to Medicaid first.

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:

- The third party carrier has been billed, and 30 days or more have passed since the date of service.
- The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit (see *Key Contacts*).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
 - the date of service.
 - the date retroactive eligibility or disability is determined.
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
 - **Medicare Crossover Claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
 - **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).

- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For more information on reasonable charges, see the *How Payment Is Calculated* chapter in this manual.


When to Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

 If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

When to Bill a Medicaid Client (ARM 37.85.406)			
	<ul style="list-style-type: none"> • Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client 	<ul style="list-style-type: none"> • Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client 	<ul style="list-style-type: none"> • Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client only for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and he or she must pay for the services received.

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for audiology and hearing aid services is \$2.00 per visit. The following clients are exempt from cost sharing:

- Clients under 21 years of age.
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed).
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page.

Coding tips

The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.

Always refer to the long descriptions in coding books.

- Attend classes on coding offered by certified coding specialists.
- Use the correct “units” measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Always check the long text of the code description.

Miscellaneous/not otherwise specified HCPCS codes

Most HCPCS Level II coding categories have miscellaneous/not otherwise specified codes. Providers must determine if an alternative HCPCS Level II code better describes the item/service being reported. These codes should only be used if a more specific code is unavailable. Claims containing a miscellaneous/not otherwise specified HCPCS must have one of the following:

- A description of the item/service attached to the claim (see *Billing electronically with paper attachments* in the *Submitting a Claim* chapter of this manual).
- A description of the item included on the claim form directly to the right or below the code used.

Failure to include such descriptions will result in the claim being denied.

Claims containing miscellaneous/not otherwise specified HCPCS codes are subject to prepayment review. Review of these claims may result in processing and payment delays. Claim processing staff are dedicated to processing claims as quickly as possible to avoid lengthy delays in payment. Providers must provide clear and complete descriptions of the item/service on the claim line or on an attachment to assist in minimizing delays. For more information on claim status, see the *Remittance Advices and Adjustments* chapter in this manual.

Prepayment review is not a prior authorization process before delivery of the item and the payment of a claim does not mean that the item/service was reviewed for its necessity and/or appropriateness. Paid claims are subject to retrospective review auditing.

Coding Resources Please note that the Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
ICD-9-CM	<ul style="list-style-type: none"> • ICD-9-CM diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
CPT-4	<ul style="list-style-type: none"> • CPT-4 codes and definitions • Updated each January 	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Place of Service

Place of service must be entered correctly on each line (see *Appendix B: Place of Services Codes*). Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Date of Service

The date of service for hearing aids or repairs is the day the hearing aid or repair is ordered from the manufacturer.

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 and/or HCPCS Level II.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- The HCPCS codes for monaural hearing aids require the use of modifiers to identify whether the aid is for the left (LT) or right (RT) ear. Use of the modifiers is mandatory for payment of monaural hearing aids. **Monaural hearing aids billed without the LT or RT modifier will be denied.**

Billings Tips for Specific Services

Hearing aids

The provider bills for hearing aids using two separate procedure codes: one for the hearing aid and one for the dispensing fee. Valid diagnosis codes are mandatory on hearing aid claims. Providers may contact the physician or mid-level practitioner for the appropriate diagnosis code in a particular case. Also, a copy of the invoice must be attached to the claim. No other attachments are required.

Handling fee for repairs

Submit claims for hearing aid repairs with one charge for each service or supply item provided, and one charge for a handling fee.

Batteries

The maximum number of hearing aid batteries is four cells per month per hearing aid. The eight cells per month limit cannot be exceeded unless prior authorization has been received from the Medicaid Services Bureau.

Hearing aid rentals

Maximum rental is 30 days. Montana Medicaid does not reimburse for a separate dispensing fee on rentals.

Submitting a Claim

See the *Submitting a Claim* chapter in this manual for instructions on completing claims forms, submitting paper and electronic claims, and inquiring about a claim.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Authorized signature missing	Each paper claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be computer generated, typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require an electronic professional claim or a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: <ul style="list-style-type: none"> • View the client's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information For Providers</i> manual.

Common Billing Errors (continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <i>Remittance Advices and Adjustments</i> in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	<ul style="list-style-type: none"> • Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the <i>PASSPORT and Prior Authorization</i> chapter in this manual).
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.
Claim past 365-day filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included (see <i>Billing Electronically with Paper Attachments</i> in the <i>Submitting a Claim</i> chapter in this manual).
Provider is not eligible during dates of services, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

Professional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **ACS field software WINASAP 2003.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFICS certifies the 837 HIPAA transactions at no cost to the provider. EDIFICS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact the EDI Technical Help Desk (see *Key Contacts*).
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFICS before submitting claims to the ACS clearinghouse. EDIFICS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing electronically with paper attachments

A copy of the hearing aid invoice must be attached to the claim. No other attachments are required.

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	888888888	-	11182003
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only.
- Client has Medicaid and Medicare coverage.
- Client has Medicaid and third party liability coverage.
- Client has Medicaid, Medicare, and third party liability coverage.
- Client has Medicaid, Medicare, and Medicare supplement coverage.

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.

- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:
 Claims Processing Unit
 P.O. Box 8000
 Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within seven to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B: Place of Service Codes</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Audiology Services and Hearing Aid Services
Client Has Medicaid Coverage Only

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1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)																																																																																																																																																																																																																																																																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky				3. PATIENT'S BIRTH DATE MM DD YY 08 19 95 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																																																																																																										
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				8. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																																																																																																										
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12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																																																																																																																																																																																																				
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																																																												
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																																																												
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																																																																																																																												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 389 0 3. _____ 2. _____ 4. _____				22. PRIOR AUTHORIZATION NUMBER 999999999				23. PRIOR AUTHORIZATION NUMBER 999999999																																																																																																																																																																																																																																																																																																																												
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25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 99999				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 148.00				29. AMOUNT PAID \$ 0.00				30. BALANCE DUE \$ 148.00																																																																																																																																																																																																																																																																																																																
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Mary Bender, 08/02/04</i> SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Hometown Audiology P.O. Box 999 Anytown, MT 59999 PIN# 0000099999 GRP# (406) 555-5555																																																																																																																																																																																																																																																																																																																												

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B: Place of Service Codes</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Overrides</i> table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>									
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Frost, Joe									
3. PATIENT'S BIRTH DATE MM DD YY 04 27 96 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same									
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) Same									
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
14. DATE OF CURRENT: MM DD YY 10 15 05									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)									
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
1 10 15 05 10 15 05 11 0 92556 1 50 00 1									
2									
3									
4									
5									
6									
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input checked="" type="checkbox"/>									
26. PATIENT'S ACCOUNT NO. 999999999ABC									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ 50.00									
29. AMOUNT PAID \$									
30. BALANCE DUE \$ 50.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Susan Pullman 08/02/04									
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)									
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Hometown Audiology P.O. Box 999 Anytown, MT 59999									
PIN# 9999999 GRP# (406) 555-5555									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B: Place of Service Codes</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Overrides</i> table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM														
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999B									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Summer, Stormie					3. PATIENT'S BIRTH DATE MM DD YY 11 14 35 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same				
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) Same				
CITY Anytown			STATE MT		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					CITY			STATE	
ZIP CODE 59999			TELEPHONE (Include Area Code) (406) 999-9999							ZIP CODE			TELEPHONE (INCLUDE AREA CODE) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE 9999999					11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 389.11 2. _____ 3. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER									
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE														
1 10 21 05 10 21 05 11 0 V5266 1 5 00 4														
2 10 22 05 10 22 05 11 0 V5266 1 5 00 4														
3														
4														
5														
6														
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Susan Pullman 08/02/04 SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Hometown Hearing Aids P.O. Box 999 Anytown, MT 59999 999999 (406) 999-9999 PIN# _____ GRP# _____				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B: Place of Service Codes</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Overrides</i> table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PICA										HEALTH INSURANCE CLAIM FORM										PICA																																							
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)										999999999																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
Doe, John										MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 9 20 97										Same																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED										7. INSURED'S ADDRESS (No., Street)																																							
98765 Anystreet #2										Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										Same																																							
CITY										8. PATIENT STATUS										CITY																																							
Anytown										Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										STATE																																							
STATE										Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>										STATE																																							
ZIP CODE										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
59999										a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										999999999A																																							
TELEPHONE (Include Area Code)										b. AUTO ACCIDENT? PLACE (State)										a. INSURED'S DATE OF BIRTH																																							
(406) 999-9999										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10d. RESERVED FOR LOCAL USE										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										999999999										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
b. OTHER INSURED'S DATE OF BIRTH																				Paywell Insurance																																							
c. EMPLOYER'S NAME OR SCHOOL NAME																				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME																				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																														13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																													
SIGNED																														SIGNED																													
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)																														15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE																													
MM DD YY																														MM DD YY																													
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE																														17a. I.D. NUMBER OF REFERRING PHYSICIAN																													
19. RESERVED FOR LOCAL USE																														18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																													
																														FROM MM DD YY TO MM DD YY																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																														20. OUTSIDE LAB? \$ CHARGES																													
1. V72.1																														<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
2. .																														22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																													
3. .																														23. PRIOR AUTHORIZATION NUMBER																													
4. .																																																											
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																																											
1 10 12 05 10 12 05 11 0 92587 26 1 45.00 1																																																											
2																																																											
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4																																																											
5																																																											
6																																																											
25. FEDERAL TAX I.D. NUMBER SSN EIN																														26. PATIENT'S ACCOUNT NO.																													
99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>																																																											
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)																														28. TOTAL CHARGE																													
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																														\$ 45.00																													
29. AMOUNT PAID																														30. BALANCE DUE																													
\$ 30.00																														\$ 15.00																													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)																														32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)																													
Mary Bender 08/02/04																														Hometown Audiology																													
SIGNED DATE																														P.O. Box 999																													
																														Anytown, MT 59999																													
																														PIN# 999999 GRP# (406) 999-9999																													

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B: Place of Service Codes</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the <i>EPSDT/Family Planning Overrides</i> table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Summers, Sammy		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same	
5. PATIENT'S ADDRESS (No., Street) 123 Sun City Road		7. INSURED'S ADDRESS (No., Street) Same	
CITY Anytown		CITY	
STATE MT		STATE	
ZIP CODE 59999		ZIP CODE	
TELEPHONE (Include Area Code) (406) 555-5555		TELEPHONE (INCLUDE AREA CODE) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Supplemental Insurance	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 389.11 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE			
1 10 10 05 10 10 05 11 0 V5256 RT 1 302.00 1			
2 10 10 05 10 10 05 11 0 V5241 RT 1 261.51 1			
3 10 10 05 10 10 05 11 0 V5266 1 5.00 4			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 568.51	
29. AMOUNT PAID \$ 314.00		30. BALANCE DUE \$ 254.51	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mary Bender 10/15/05		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Hometown Hearing Aids P.O. Box 999 Anytown, MT 59999		PIN# 999999 GRP# (406) 999-9999	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors	
Claim Error	Prevention
Required field is blank	Check the claim instructions in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see <i>Prior Authorization and PASSPORT</i> in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, computer generated, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be included with the claim or it will be denied.

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form*, have internet access, and be registered for the Montana Access to Health Web Portal. You can access your electronic RA through the Web Portal on the internet by going to the Provider Information website (see *Key Contacts*) and selecting Provider Services. In order to access the Montana Access to Health Web Portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the *Required Forms for EFT and/or Electronic RA* table in this chapter).

After these forms have been processed, you will receive a user ID and password that you can use to log on to the Web Portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Web Portal home page. Due to space limitations, each RA is only available for 90 days.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.



Electronic RAs are available for only 90 days on the web portal.



If a claim was denied, read the reason and remark code description before taking any action on the claim.

Sections of the Paper RA	
Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see <i>Adjustments</i> later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending claims	<p>All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.</p>
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES HELENA, MT 59604									
MEDICAID REMITTANCE ADVICE									
1 HOMETOWN AUDIOLOGY P.O. BOX 999 ANYTOWN, MT 59999									
2	3	4	5	6					
PROVIDER# 0001234567	REMIT ADVICE #123456	WARRANT # 654321	DATE:08/15/05	PAGE 2					

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO- PAY	REASON/ REMARK CODES
7	8	10	11	12	13	14	15	16
PAID CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	070105 070105	1	92522	25.00	15.00	Y	
9	ICN 0041830050000700	***LESS MEDICARE PAID*****						
		LESS COPAY DEDUCTION**				2.00		
		CLAIM TOTAL **			25.00	13.00		17
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JANE	070105 070105	1	92563	25.00	0.00	N	
	ICN 0041830050000800							
		CLAIM TOTAL **			25.00			17
								31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, SUSAN	070105 070105	1	92568	25.00	0.00	N	133
	ICN 0041830050000900	070105 070105	1	92568	25.00	0.00	N	133
		CLAIM TOTAL **			380.00			

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE*****

31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
133	THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
MA61	DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key to the Paper RA	
Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider when applying for Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u> A B C D E</p> <p>A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day; the same date will appear in both columns
11. Unit of service	The number of services rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Co-pay	A "Y" indicates cost sharing was deducted, and an "N" indicates cost sharing was not deducted from the payment.
16. Reason/Remark Code	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, Billed Amount, and Paid Amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By “working off” the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter.
- The time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check, or request Provider Relations to complete a gross adjustment.

Rebilling Medicaid

Rebilling occurs when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* chapter in this manual.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).

The Credit Balance section is informational only. Do not post from credit balance statements.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter.)

Rebill denied claims only after appropriate corrections have been made.

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. An adjustment form should be used for claims with denied lines that have codes that must be billed together (see *Adjustments*).
- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Submitting a Claim, Claim Inquiries*). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit over will be a 2, indicating an adjustment. See the *Key to the Paper RA* in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table, *Completing an Individual Adjustment Request Form*).
2. Complete *Section B* with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
 - Enter the date of service or the line number in the *Date of Service or Line Number* column.
 - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
 - Enter the correct information in the column labeled *Corrected Information*.
3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.

MONTANA MEDICAID/MHSP/CHIP INDIVIDUAL ADJUSTMENT REQUEST			
INSTRUCTIONS: This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the <i>Remittance Advices and Adjustments</i> chapter in your program manual or the <i>General Information For Providers II</i> manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).			
A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION			
1. PROVIDER NAME & ADDRESS Hometown Audiology Name P.O. Box 999 Street or P.O. Box Anytown, MT 59999 City State Zip		3. INTERNAL CONTROL NUMBER (ICN) 00404011250000600 4. PROVIDER NUMBER 1234567 5. CLIENT ID NUMBER 123456789 6. DATE OF PAYMENT 10/01/05 7. AMOUNT OF PAYMENT \$ 180.00	
2. CLIENT NAME Jane Doe			
B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED			
	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	09/01/05	09/15/05
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC) SIGNATURE: <u>Mary Bender</u> DATE: <u>10/15/05</u> When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC). MAIL TO: ACS P.O. Box 8000 Helena, MT 59604			

Sample Adjustment Request

5. Send the adjustment request to Provider Relations (see *Key Contacts*).
 - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
 - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* in this chapter).
 - Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name is here.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field #5 (see the sample RA in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field #17 (see the sample RA in this chapter.).
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/ N.D.C/ Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly *Claim Jumper*, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a “4” (see *Key to the Paper RA* in this chapter).

Payment and the RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider’s bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider’s account, all Medicaid payments will be made through EFT. To arrange for EFT, call the number listed under *Direct Deposit Arrangements* in *Key Contacts*.



Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Required Forms for EFT and/or Electronic RA
All four forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health Web Portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement)	<ul style="list-style-type: none"> • Provider Information website • Provider Relations (see <i>Key Contacts</i>) 	Provider Relations (see <i>Key Contacts</i>)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider Information website (see <i>Key Contacts</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allows provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form)	<ul style="list-style-type: none"> • Provider Information website • ACS EDI Gateway website (see <i>Key Contacts</i>) 	ACS address on the form

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers.

Payment for Audiology Services

Medicaid payment for audiology services will be the lower of the provider's usual and customary charge for the service or 90 percent of the published RBRVS fee.

Payment for Hearing Aid Services

Medicaid payment for covered hearing aid services and items will be the lower of the provider's usual and customary charge for the service or item, the submitted price on the invoice, or the Department's fee schedule.

How Cost Sharing Is Calculated on Medicaid Claims

Client cost sharing for services provided by audiology services and hearing aid services providers is \$2.00 per visit. The client's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, an audiology services provider supplies a Medicaid client with air and bone audiometry (92553). The Medicaid allowed amount in November 2005 for this item is \$16.99. The client owes the provider \$2.00 for cost sharing, and Medicaid would pay the provider the remaining \$14.99.

How Payment Is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of*



Many Medicaid payment methods are based on Medicare, but there are differences, in these cases, the Medicaid method prevails.

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge.
- Modifiers (see *Other modifiers* in this chapter).
- Provider type (see *Professional differentials* in this chapter).
- Place of service (see *Site of service differential* in this chapter).
- Date of service (fees for services may change over time).
- Also check for cost sharing and Medicare or TPL payments which will be shown on the remittance advice.

Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a Medicaid client who also has insurance through her job receives a monaural hearing aid to wear behind her right ear (V5060RT). The invoice amount is \$375.00. The client's other insurance is billed first and pays \$200.00. The Medicaid allowed amount for this item is the invoice amount up to \$400.00. The amount the other insurance paid (\$200.00) is subtracted from the Medicaid allowed amount (\$375), leaving a balance of \$175.00. The Medicaid cost sharing (\$2.00) is deducted from the balance, leaving a net payment of \$173.00 on this claim.

How Payment Is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the Medicare co-insurance and deductible amounts not to exceed the Medicaid fee for the service for these dually eligible individuals. See the *How Payment Is Calculated* chapter in the *Physician Related Services* manual for examples on how payment is calculated on Medicare crossover claims.

The RBRVS Fee Schedule

Most audiology services are paid for using the Department's RBRVS fee schedule. RBRVS stands for Resource-Based Relative Value Scale. The fee schedule includes about 7,700 CPT-4 codes and about 1,600 HCPCS Level 2 codes.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in August 1997. It is based largely on the Medicare model, with a few differences that are described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the millions of dollars of research performed by the federal government and national associations of physicians and other health care professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, BlueCross BlueShield plans, workers' compensation plans and commercial insurers.

The following paragraphs elaborate on aspects of the RBRVS fee schedule used by the Department. All numerical examples are from November 2005 and may not apply at other times.

Fee calculation

Each fee is the product of a relative value times a policy adjuster times a conversion factor. For example, the fee for a comprehensive hearing test (92557) is:

$$1.132 \text{ relative value units} \times .92 \text{ policy adjuster} \times \text{conversion factor of } \$32.59 = \$33.94$$

Basis of relative values

For almost all services, Medicaid uses the same relative values as Medicare does in Montana. (Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality.) For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

Composition of relative values

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated practice expense and the associated malpractice expense. For a spontaneous nystagmus test (92541), for example, the composition is as follows:

.40 work RVUs + 1.03 practice expense RVUs + 0.04 malpractice expense RVUs = 1.47 total RVUs

Site of service differential

The Medicare program has calculated two sets of relative values for each code – one that reflects the practitioner’s practice cost of performing the service in an office and one that reflects the practitioner’s practice cost of performing the service in a hospital or ambulatory surgical center (ASC). When services are provided within a hospital or ASC (i.e., places of service 21, 22, 23, and 24), Medicaid typically pays a lower fee than if the service is provided in the office or another setting. The reason is that Medicaid typically also pays the hospital or ASC for the service. For example, in November 2005 Medicaid would pay a provider for an oral speech device evaluation (92597) as follows:

In office: 2.341 RVUs x .92 policy adjuster x conversion factor of \$32.59 = \$70.19

In hospital or ASC: 1.274 RVUs x .92 policy adjuster x conversion factor of \$32.59 = \$38.20

Conversion factor

The Department sets the conversion factor for the state fiscal year (July through June). The conversion factor is typically reviewed (and often changed) in July of each year. In July 2005 it was updated to \$32.59, compared with the Medicare conversion factor of \$37.8975.

Global periods

For many surgical services, the fee covers both the service and all related care within a specified “global” period. For almost all such codes, the global periods used by Medicaid are identical to those used by Medicare, but in cases of differences the Medicaid policy applies. See the *Billing Procedures* chapter in this manual for more information on global periods.

Professional and technical components

Some services are divided into the technical component (performing the test) and the professional component (interpreting the test). A practitioner who only performs the test would bill the service with modifier TC; a practitioner who only interprets the test would bill with modifier 26; and a practitioner who performs both components would bill the code without a modifier. (Performance of both components is called the global service.) The fee schedule has separate fees for each component and for the global service. Consider a spontaneous nystagmus test:

92541-TC: 0.740 RVUs x .92 policy adjuster x conversion factor of \$32.59
= \$22.19

92541-26: 0.581 RVUs x .92 policy adjuster x conversion factor of \$32.59
= \$17.42

92541: 1.322 RVUs x .92 policy adjuster x conversion factor of \$32.59 =
\$39.63

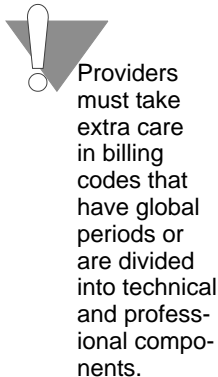
Other modifiers

Under the RBRVS fee schedule, certain other modifiers also affect payment. As of July 2002, these are shown in the following table.

How Modifiers Change Pricing

- Modifiers may not be applicable for all services. For services paid via the RBRVS fee schedule, the fee schedule shows the list of services for which modifiers 26, TC, 50, 51, 62, 66 and 80 apply.
- If a modifier does not appear in this list, then it does not affect pricing.
- The list shows summary modifier descriptions. See the CPT-4 and HCPCS Level II coding books for the full text.

Modi- fier	Definition	How it affects payment
21	Prolonged evaluation and management	The service is paid at 110% of fee.
22	Unusual procedural service	Pay by report.
26	Professional component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 40% of the fee.
47	Anesthesia by surgeon	Pay by report
50	Bilateral procedure	The procedure is paid at 150% of the fee.
51	Multiple procedures	Each procedure is paid at 50% of the fee.
52	Reduced service	The service is paid at 50% of the fee.
53	Discontinued procedure	The service is paid at 50% of the fee.
54	Surgical care only	The service is paid at 75% of the fee.
55	Postoperative management only	The service is paid at 25% of the fee.
56	Preoperative management only	The service is paid at 25% of the fee.
62	Two surgeons	Each surgeon is paid at 62.5% of the fee.
66	Surgical team	Each surgeon is paid by report.
80	Assistant surgeon	The service is paid at 16% of the fee.



How Modifiers Change Pricing (continued)		
Modifier	Definition	How it affects payment
81	Minimum assistant surgeon	The service is paid at 16% of the fee.
82	Assistant surgeon; qualified resident surgeon not available	The service is paid at 16% of the fee.
90	Reference laboratory	Modifier not allowed.
AD	Medical supervision of more than four concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
AS	Physician assistant, nurse practitioner or clinical nurse specialist as assistant at surgery	The service is paid at 16% of the fee.
QK	Medical supervision of 2-4 concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
QZ	Certified registered nurse anesthesiologist service without medical direction	The modifier does not reduce the fee, but a professional differential of 90% is applied due to provider type. See <i>Professional differentials</i> in this chapter.
SA	Nurse practitioner	Payment equals 90% of the fee for some services but 100% for others. See <i>Professional differentials</i> in this chapter.
SB	Nurse midwife	Payment equals 90% of the fee for some services but 100% for others. See <i>Professional differentials</i> in this chapter.
TC	Technical component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 60% of the fee.

Professional differentials

For some services within the scope of RBRVS payment methods, mid-level practitioners are paid differently. Audiologists are paid at 90% of the fee schedule.

Charge cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by report

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at a percentage of the provider's charge. As of July 2004 the percentage was 45% for audiology services. For hearing aid services, the percentage depends on provider type and service/supply. The Department typically reviews this percentage each July.

Bundled codes

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. Because these services are covered by Medicaid, providers may not bill clients for them on a private pay basis. Audiology codes are not bundled.

Status codes

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the following table.

Table A			
Medicare and Medicaid RBRVS Status Values			
Medicare Status		Medicaid Status	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K or X status]
F	Deleted/discontinued code; no grace period	D	Discontinued code
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered
Notes:			
<ul style="list-style-type: none"> • Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N or X. • Medicare uses the label “injections” for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day. 			

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Appendix A: Forms

- *Montana Medicaid /MHSP/CHIP Individual Adjustment Request*
- *Montana Medicaid Claim Inquiry Form*
- *Paperwork Attachment Cover Sheet*
- *Hearing Aid Request for Authorization*
- *Hearing Aid Certificate of Medical Necessity*

**MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST**

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **ONLY** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS _____ Name _____ Street or P.O. Box _____ City State Zip	3. INTERNAL CONTROL NUMBER (ICN) _____ 4. PROVIDER NUMBER _____ 5. CLIENT ID NUMBER _____ 6. DATE OF PAYMENT _____ 7. AMOUNT OF PAYMENT \$ _____
2. CLIENT NAME _____	

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC) 			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

**MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604**

Montana Medicaid Claim Inquiry Form

Provider Name _____
 Contact Person _____
 Address _____
 Date _____
 Phone Number _____
 Fax Number _____



For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____

Mail to:

Provider Relations
 P.O. Box 8000
 Helena, MT 59604

Fax to: (406) 442-4402

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

MONTANA MEDICAID PRIOR AUTHORIZATION REQUEST FORM
Hearing Aid Services (Rev. May 2006)

MONTANA
Department of Public Health & Human Services

MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

Hearing Aid Services (Rev., July 2003)

HEARING AID EVALUATION

Patient Name, Address, Telephone Number, Date of Birth

Audiologist Name, Address, Telephone Number

Medicaid Number

Referring Physician Name, Address, Telephone Number

Date of Evaluation/Referral _____

Diagnosis

Date of Audiological Examination

Audiometric Test Results:

Right Ear

Left Ear

500Hz

_____ / _____

1000Hz

_____ / _____

2000Hz

_____ / _____

3000Hz

_____ / _____

Total Average

_____ / _____

PB Max Level

_____ / _____

Y / N

The two-frequency average at 1 KHZ and 2 KHZ is greater than 40 decibels in both ears.

Y / N

The two-frequency average at 1 KHZ and 2 KHZ is less than 90 decibels in both ears.

Y / N

The two-frequency average at 1 KHZ and 2 KHZ has an interaural difference of less than 15 decibels.

Y / N

Word recognition or speech discrimination score is not greater than 20%.

Comments/Recommendations

I certify that I am the audiologist completing the audiological evaluation for the patient identified in this form. I certify that the information contained in this document and its attachments are true, accurate, complete and supported by clinical information in the patients record. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Audiologist Signature _____ Date ____/____/____ (Stamps Are Not Acceptable)

Attachments: This form must be accompanied by copies of supporting documentation to include, but not limited to the physician=s referral for hearing aid services, diagnostic and evaluation reports. Attachments are necessary for dispenser to request approval of the hearing aid(s) prior to the actual dispensing of the aid(s).

Appendix B:

Place of Service Codes

Place of Service Codes		
Codes	Names	Descriptions
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

**Revised effective October 1, 2005.

Place of Service Codes (continued)		
Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

Place of Service Codes (continued)		
Codes	Names	Descriptions
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

Place of Service Codes (continued)

Codes	Names	Descriptions
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)

The rules published by the executive departments and agencies of the state government.

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider

Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits

A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Audiology Services

Hearing aid evaluation (HAE) and basic audio assessment (BAA) provided by a licensed audiologist, upon physician or mid-level practitioner referral, to individuals with hearing disorders.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

By Report

For services, supplies, or equipment that do not have a maximum allowance established, Montana Medicaid reimburses the provider based on a percentage of the provider's usual and customary charge for the allowed item or service. These items are identified in the Department's fee schedule.

Cash Option

Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)

This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim

A claim that can be processed without additional information from or action by the provider of the service.

Client

An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Coinsurance

The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor

A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment

The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic

Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing

The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers

Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis

for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles

Clients who are covered by Medicare and Medicaid are often referred to as “dual eligibles.”

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental

A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department’s direction and in accordance with ARM 37.86 et seq.

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

Hearing Aid

An instrument or device designed for or represented as aiding or improving defective human hearing and includes the parts, attachments or accessories of the instrument or device.

Hearing Aid Dispenser or Dispenser

A person holding a current license issued by the Montana Board of Hearing Aid Dispensers under Title 37, Chapter 16, MCA to engage in selling, dispensing, or fitting hearing aids. The term does not include any person to the extent that the person acts beyond the scope of the person’s hearing aid dispenser license.

Incurment

The amount a Medicaid client has to pay for their medical services before Medicaid will pay for services. See *Coverage for the Medically Needy* in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

A non-covered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Maximum Allowable

The maximum dollar amount for which a provider may be reimbursed as established by Montana Medicaid for specific services, supplies and/or equipment.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)

A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or mal-function. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible

for Medicaid, and have a family income that does not exceed an amount established by the Department.

Montana Breast and Cervical Cancer Treatment Program

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

PASSPORT To Health

A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay

When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.
- For audiology service, a licensed audiologist individually enrolled in Montana Medicaid. For hearing aid services, is a licensed hearing aid dispenser individually enrolled in Montana Medicaid.

Qualified Medicare Beneficiary (QMB)

QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit

The numerical value given to each service in a relative value scale.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)

SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down

Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care

A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. <http://vhsp.dphhs.state.mt.us>

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact the EDI Technical Help Desk (see *Key Contacts*).

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